

Child Fatality and Near Fatality External Review Panel

Virtual Meeting

Tuesday, August 17, 2021

MINUTES

Members Present: Hon. Dawn Blair, Assistant Hardin County Attorney, Co-Chair; Lesa Dennis as proxy for Commissioner Marta Miranda-Straub, Department for Community Based Services, Janice Bright, RN, State Child Fatality Review Team; Lori Aldridge, Executive Director, Tri County CASA; Isela Arras, Kentucky Coalition Against Domestic Violence; Dr. Elizabeth Salt, Citizens Foster Care Review Board; Dr. Henrietta Bada, Department for Public Health; Dr. William Ralston, Chief Medical Examiner; Dr. David Lohr, Medical Director, Department for Community Based Services; Dr. Jaime Pittenger Kirtley, Prevent Child Abuse Kentucky; and Steve Shannon, Executive Director, KARP.

Welcome:

Hon. Dawn Blair, Co-Chair

Dawn Blair welcomed everyone to the meeting and asked if anyone had any changes to the minutes or case summaries. With no changes, Steve Shannon made a motion to accept the minutes and case summaries which was seconded by Dr. Elizabeth Salt. Minute and Case Summaries stand as submitted.

Pending Cases:

NF-002-20-C – Case will be reviewed during the September meeting.

F-052-20-C – During the previous meeting the Panel requested a new CPS referral be made, however the referral was not accepted for investigation. Due to the caregiver's inactions and being a registered nurse, the panel requested a referral be made to the Kentucky Board of Nursing. The KBN did accept the request and currently investigating the matter.

NF-109-20-C – During the previous meeting, DCBS was asked to follow-up on if CCMC had UK PFM's report prior to their initial consult and if CPS followed up with PFM before their final determination? The ADT indicated the CCMC did review the relevant records prior to their consult with DCBS. It is further noted that the family requested the second opinion from CCMC and DCBS has no reason to believe the worker did anything unprofessional. There was no indication in the record that the worker consulted with PFM prior to making their final determination. However, there is no obligation for the worker to consult with PFM regarding a second medical opinion. DCBS could not determine how it occurred, if it was purely accidental, or who could have injected that child with insulin.

Case Review:

The following cases were reviewed by the Panel. A case summary of findings and recommendations are attached and made a part of these minutes.

<u>Group</u>	<u>Case #</u>	<u>Analyst</u>
1	F-031-20-C	Joel Griffith
2	F-022-20-C	Joel Griffith

3	F-050-20-C	Joel Griffith
4	NF-010-20-C	Joel Griffith
1	NF-029-20-C	Joel Griffith
2	NF-030-20-C	Joel Griffith
3	NF-066-20-C	Joel Griffith
4	NF-069-20-NC	Joel Griffith
1	NF-112-20-C	Cindy Curtsinger
2	NF-117-20-C	Cindy Curtsinger
3	NF-072-20-C	Joel Griffith
1	F-001-20-NC	Cindy Curtsinger
2	F-017-20-C	Joel Griffith
3	NF-049-20-C	Joel Griffith
4	NF-050-20-C	Joel Griffith
1	NF-052-20-C	Joel Griffith
2	NF-067-20-C	Joel Griffith
3	NF-071-20-NC	Joel Griffith
4	NF-076-20-NC	Joel Griffith
1	NF-080-20-C	Joel Griffith
2	NF-094-20-NC	Cindy Curtsinger

* NF-056-20-C will be reviewed during the September meeting

Additional Discussion:

Plans of Safe Care Discussion – Panel members discussed how to improve the communication between the birthing hospitals and the pediatricians post discharge. As it is done currently, the hospital schedules an appointment with the pediatrician and provides them with a copy of the discharge papers and notice of the DCBS referral. However, the birthing hospital would not know if the family actually attends that appointment. If DCBS does not accept the referral, there would be no follow up by them either. It was suggested that the birthing hospital make a call to the pediatrician office and explain the history. The panel discussed that perhaps the electronic medical records, especially within larger facilities, would produce some sort of red flag notifying other providers that this is a high risk family. However, the more rural hospitals would still require some type of direct communication with the pediatrician. Panel staff discussed how do you fully operationalize a “warm hand-off”. If that could be put into a letter the panel could distribute it to the Kentucky Hospitals Association, KAAP, and other providers. DCBS staff informed the panel that they currently have a workgroup with Dr. Currie to discuss how to operationalize the warm hand-off.

Meeting adjourned